Dr. / Mr. / Mrs. / Ms. / Miss

*Name:_____ Sex _____Date of Birth_____

Race: _____Ethnicity: _____Refused: ☐

*Marital Status: **M W S D SEP**

*Mailing Address: _____

*City:_____ State:_____ Zip Code:_____

*Home Phone: (_____)_____Cell Phone #: (_____)_____

*Social Security #:_____

*E-mail Address: _____: **Don't' Have One** **Refused** **No Promo's**

Employer:_____ Phone: (_____)_____

*Primary Care Physician:_____ MD Phone: (_____)_____

PCP Address: _____

Is this a work related injury? _____Yes _____NO

*****Health Insurance Coverage

Insurance Company Name:_____

Member ID#:_____ Group #:_____ Co-Pay:_____

Effective Date of Ins:_____ Relation to insured: _____self _____spouse _____child

Secondary Coverage if applicable (Example: Medicare and Medex)

Insurance Company Name:_____

Member ID#:_____ Group #:_____ Co-Pay:_____

Effective Date of Ins:_____ Relation to insured: _____self _____spouse _____child

Insurance Subscriber Information Same as above ☐

Insurance Policy Holder's Name: _____

Sex:_____ Date of Birth:_____Social Security #:_____

Address:_____ Home Phone:_____

City:_____ State:_____ Zip Code: _____

Employer:_____ Phone: (_____)_____

Worker's Compensation ☐ or Auto Insurance ☐

Insurance Carrier Name:_____

Address:_____ Phone #:_____

City:_____ State:_____ Zip Code:_____ Fax #:_____

Claim #:_____ Date of accident:_____Adjuster:_____

UR Company: _____ Phone #:_____

***How did you hear about us? (*PLEASE BE SPECIFIC*)**

Primary Care MD_____ Friend/Relative_____ Radio_____

Specialty Care MD_____ Internet/Website_____ Other_____

Newspaper _____ Salon _____ Yellow pages_____

Authorization for Release of Information

I authorize Health professionals, using their best judgment, to disclose to a **family member, relative, or any other person I identify** (see below), health information relevant to that person's involvement in my care or payment related to my care. **The person listed below will also be considered your emergency contact person.**

Name:_____ Relationship: _____ Phone: (H)_____ (W) _____

Name:_____ Relationship: _____ Phone: (H)_____(W) _____

Extended Authorization for: Dr. Ekstrom

I hereby authorize ***my physician*** to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to my physician all payments for medial services rendered to myself, or my dependents. I understand that I am financially responsible for all charges not covered by my insurance, including those resulting from my failure to obtain a referral or to give correct insurance information.

Signature:_____ Date:_____

Consent for Treatment

I hereby request and voluntarily consent to such office care, including routine diagnostic procedures and medical treatment, as may be deemed necessary by ***Dr. Ekstrom*** and/or its designees.

Signature:_____ Date:_____

Our goal is to respond to all of our patient's needs and to provide the highest quality care. We invite you to complete the following questionnaire to achieve your desired health and appearance of your skin.

*Please check all that apply:

- o Lines around my eyes
- o Lines between my eyes (angry look)
- o Lines on forehead
- o Lines under eyes
- o Puffy eyes
- o Thin lips
- o Dry skin
- o Oily skin
- o Looking tired
- o Crease nose to corner of mouth
- o Frown on corner of mouth
- o Brown spots on face
- o Red, blotchy skin
- o Excess skin above eyes
- o Thin face, no cheeks
- o Dimpled chin
- o Gummy smile
- o Sunk in eyes

*Procedures or products of interest to you (please check all that apply)

- o Botox Cosmetic
- o AHA and Glycolic Peels
- o Collegen Therapy
- o Skin Rejuvination
- o Retin-A or Retinol
- o Acne
- o Chemical Peels
- o Laser resurfacing
- o Photorejuvination
- o Skin Care Advice
- o Skin Care Products
- o EndyMed (Non surgical skin tightening)
- o Liver spots/Age spots
- o Sunscreen Advice
- o Facials and Eye Treatment
- o Laser hair Removal
- o Spider Vein Treatments
- o Removing Facial Veins

Other, please specify _____